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Modernising medical careers, the Foundation Programme and psychiatry

The stated aim of the new Foundation Programme is to equip all doctors with a range of generic competencies before they embark on a specialist training programme, following the advice in *Modernising Medical Careers* (Department of Health, 2003, 2004), which built upon *Unfinished Business, Proposals for the Reform of the Senior House Officer Grade* (Department of Health, 2002). The educational aims of this 2-year programme are to develop generic skills, competencies and attitudes to ensure professional conduct that will reflect 'good medical practice' as defined by the General Medical Council (1998). Any education for the Foundation Programme must concentrate on these areas. A Curriculum for the Foundation Years in Postgraduate Education and Training is being produced by the Academy of Medical Royal Colleges in co-operation with the Modernising Medical Careers Implementation Team at the Department of Health (Department of Health, 2005).

As there will be a focus on acute care as well as generic skills, the Academy of Royal Colleges has grouped acute presentations ('acute care scenarios') in terms of patients who have airway problems, breathing problems, circulation problems, neurological problems, psychological/behavioural problems and pain. Therefore, all trainees will be expected to be aware of National Guidelines for the above, have the ability to manage a cardiac arrest by having an up-to-date immediate or advanced life support certificate (or equivalent), understand how these presentations differ in the elderly and in children, and recognise vulnerable patients, as well as understand the principles of child protection.

The experience in psychiatry in a foundation year could represent an induction to basic specialist training in psychiatry itself or to general practice or general medicine. The Foundation Programme is not simply an opportunity to commence specialty training in a different format. Undoubtedly the competencies acquired will be of value to the future specialist career of doctors involved, but this is not the sole or primary concern of the new integrated programme.

Intended learning outcomes in psychiatry: the Foundation Programme

Although the general model of provision will be of three 4-month attachments, there is a need to develop some basic skills for all doctors, by including psychiatry as a day release option within some Foundation Programmes or having brief attachments lasting from 1 to 2 weeks. Psychiatry can offer important and unique opportunities to develop competencies, particularly in domains of knowledge, judgement and professionalism. Skills for clinical examination, including history-taking and mental state examination, skills of judgement in formulation of cases and risk assessment, and skills of professionalism, including working with other agencies and the development of ethical practice, will all be improved. The best structure for the programme would be for trainees to work in three units of 4-month placements with a single educational supervisor throughout the 12 months. Trainees would stay in one locality, which would enable them to consolidate learning. The educational supervisor would work with individual consultant teachers, taking overall responsibility for the teaching and development of the individual, careers advice and the coordination of assessment processes.

The programme must prepare individuals to practise according to standards defined by the General Medical Council (1998). Essential elements are professional competence, good relationships with patients and colleagues, and observance of professional ethical obligations. Good clinical care for psychiatry must include not only knowledge of the signs and symptoms of common psychiatric disorders but also an understanding of the epidemiology and aetiology of these disorders. An understanding of referral pathways and emergency management and treatment packages, along with prognostic factors and outcomes, will be crucial. Principles of multiprofessional team working and a knowledge of the role of individual members within multiprofessional teams, as well as a knowledge of legislation applied in mental health work and associated ethical dilemmas, are important learning points. These can be developed into an outcome-based curriculum by way of individual statements of intent (Box 1).

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Box 1. Aims, objectives and outcomes of the psychiatry programme

Aims

- To produce doctors with knowledge and competency to treat common psychiatric conditions

Objectives

- To identify mechanisms underlying an exemplar condition, e.g. depression
- To develop skills in history-taking and mental state examination for an exemplar condition, e.g. depression

Intended learning outcomes

- Attain and utilise knowledge and skills required to treat common psychiatric conditions
- Identify and summarise mechanisms underlying an exemplar condition, e.g. depression
- Acquire and demonstrate skills in history-taking and mental state examination for an exemplar condition, e.g. depression

Generic skills programme

Most placements in psychiatry are likely to be in the second year, when doctors will develop generic skills and competencies, including enhanced clinical skills (including assessment and management of emergencies), effective relationships with patients, high standards in clinical governance and patient safety, effective use of evidence and data, communication, team working, multiprofessional practice, time management and decision-making and an effective understanding of the different settings in which medicine is practised.

Learning methods

Trainees will continue to employ a number of learning methods as before; for example, classroom-based learning, where a weekly half-day programme will cover generic skills and subject-specific skills. Within the subject (i.e. the psychiatry component), the programme should cover common psychiatric disorders, their presentation and treatment, and introduce the skills involved in clinical assessment through workshop formats involving simulated patients. On the other hand, in patient-based learning the core of the learning is by way of experience with real (and simulated) patients. In multiple and varied settings trainees must gain an understanding of the impact of the patient as a person on a family and societal system; physical, psychological, social and cultural dimensions of problems presented; and the difference between disease and illness. By following patients' journeys throughout their contact with services, from the presentation of acute illness, through investigation, diagnosis and management to recovery or rehabilitation, the trainees can synthesise their skills and competencies.

There is no doubt that trainees will benefit from the personal attention of enthusiastic, knowledgeable teachers and contact with patients. The emphasis of all the learning should be on clinical relevance, and real cases, case vignettes and videos will help to bring the subject to life. Where possible, links should be made to other components of the Foundation Programme, particularly general practice.

Educational supervision

The success of the programme will depend upon skilled, organised and enthusiastic educational supervisors. Supervisors will work with trainees throughout their 1-year programme. Their responsibilities will include assessment, appraisal, career guidance, evaluation of educational programmes and pastoral care. They will generally be experienced medical educators, working closely with other important local figures or bodies such as deaneries, universities and clinical tutors to ensure the development and delivery of Foundation Programmes. Not all consultant trainers will be educational supervisors, but it is hoped that a good number of psychiatrists will emerge in this role. Supervision is a formal process giving an academic perspective to questions arising from direct patient care.

Introduction to psychiatry curriculum for Foundation Year 2

Short-duration release (week, fortnight or day release) for attachments in psychiatry is another way of introducing trainees to psychiatry. This may be particularly suited to those considering specialisation in general medicine or paediatrics, but will also be of great interest to those considering most other specialties. The attachments must be well planned and focused, with agreed aims to be achieved and an understanding of how the attachment will be assessed. A 1-week attachment may provide at least 40 h of specific interaction and a 2-week attachment up to 80 h.

During the attachment trainees should obtain an appreciation of the way that psychiatry contributes to individual patient management in a range of settings and in different patient groups, including prevention, assessment, diagnosis, treatment and follow-up, and the contribution to protection of vulnerable individuals and children. They should learn about the use of physical, social and psychological investigations for common psychiatric disorders, general principles underlying diagnosis and treatment choice, commonly used pharmacological and psychological treatments, and the career opportunities in psychiatry.

Resource requirements

In order to deliver all this, the Foundation Programme must be organised in a coordinated and coherent manner by a team of trained clinical and educational supervisors. Resources to deliver this programme must be identified and ring-fenced, and protected time for teaching will have to be secured.

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Assessment

Assessment of the management of acute cases will involve both the skills of acute care and also the generic skills (e.g. team work, communication and identification of priorities) that underpin that performance. Evidence of skills acquisition will almost certainly include the submission of a portfolio and workplace assessments of clinical and non-clinical competencies. Thus the assessment process will, in large part, be the trainees' responsibility to lead and will include assessment of clinical skills (mini clinical examination exercise and case-based discussion), practical skills (direct observation of procedural skills), personal skills (multi-source feedback 360-degree assessment) and submission of completed audit. These will feed an annual review of assessment evidence for the purpose of 'graduation' from foundation to specialist training. All doctors will be expected to participate in contemporary National Health Service (NHS) appraisal systems.

Principal challenges

Challenges include determination of basic job structures and resolving tensions between service learning and training needs. Approval 'mechanisms' for these posts will lie with local postgraduate deaneries. Processes will need to be determined for the selection of trainers, the development and accreditation of training posts and the refinement of assessment schedules, including valid workplace assessment tools for mental health competencies. Programmes suitable for flexible training and for non-UK graduates will need to be developed. The entry to specialist training will need to be adapted to reflect the changing input following inception of Foundation Programmes, and there will need to be provision of suitable career advice for all trainees. Psychiatry will need to work closely with other specialties, particularly community-based medicine and acute medical specialties.

Perhaps the most pressing challenge for psychiatry lies in the very creation of the posts. There was an increase in the number of National Training Numbers for psychiatry this year, in recognition of the need to create more training opportunities at the basic specialist level, in order to feed higher training and thus boost consultant recruitment. The posts were not centrally funded and thus hard-pressed trusts found it difficult to fund them. A majority of trusts responded by re-engineering medical staffing budgets, for example, by redeploying funding from vacant staff and associate specialist grade posts. Despite strenuous efforts from all concerned this has left a large number of posts that cannot be taken up. If the same system is adopted for foundation posts then a similar result can be expected. This could result in further marginalisation of psychiatry from the process, with a potentially harmful effect on recruitment for the future as the 'shop window' is denied. Therefore, if the 'opportunity' described by Herzberg *et al* (2004) – which is undoubtedly there – is to be realised, then deaneries and the Modernising Medical Careers Strategy Group may need to secure additional central resources to establish much-needed (and potentially much-valued) posts.

The way forward

There is no doubt that these aims are laudable, but in order to fulfil them the Foundation Programme has to be delivered in a coordinated and coherent manner by a team of trained clinical and educational supervisors. Resources to deliver this programme must be identified and secured. Of these, the most important will be the identification and training of teachers. It is also clear that protected time for teaching will have to be secured. The Royal College of Psychiatrists is committed to providing appropriate training in these areas for trainees and their supervisors. There may be particular needs in the area of assessment and the development and use of workplace assessment tools, which we are working on. However, trusts must consider the vital part played by those involved in the Foundation Programme when considering job planning and reward systems for doctors.

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